106TH CONGRESS
1ST SESSION

H. R. 2089

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 1999

Mr. BOEHNER introduced the following bill; which was referred to the Committee on Education and the Workforce

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A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Group Health Plan Review Standards Act of 1999".

SEC. 2. SPECIAL RULES FOR GROUP HEALTH PLANS.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended—

(1) by inserting "(a) IN GENERAL.—" after "SEC. 503.";

(2) by inserting "(other than a group health plan)" after "employee benefit plan"; and

(3) by adding at the end the following new subsection:

"(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

"(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

"(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the average participant;

"(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision;

"(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 90 days after receipt of the notice of the initial decision, for a full and fair review of the decision by an appropriate named fiduciary who did not make the initial decision; and

"(D) meet the additional requirements of this subsection.

"(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

"(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

"(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such

reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (10)(I) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

"(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision

of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

"(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO ACCELERATED NEED MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

"(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan before the end of the accelerated need decision period under paragraph (10)(K), in cases involving accelerated need medical care, following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the

request for purposes of internal review under clause (ii).

"(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision before the end of the accelerated need decision period under paragraph (10)(K) following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

"(3) MEDICAL PROFESSIONALS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENT OR TECHNOLOGY.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute investigational items or experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to investigational items or experimental treatment or technology, shall be conducted by a physician or, if appropriate, another medical professional, who is selected by the plan and who did not make the initial denial.

"(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

"(A) IN GENERAL.—In any case in which a participant or beneficiary, who has received an adverse coverage decision which is not re-

versed upon review conducted pursuant to paragraph (1)(C) (including review under paragraph (2)(A)(ii) or (2)(B)(ii)) and who has not commenced review of the coverage decision under section 502, makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the requirements of subparagraphs (B), (C), (D) and (E) shall apply in the case of such adverse coverage decision, if the requirements of clause (i), (ii), or (iii) are met.

"(i) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEM OR EXPERIMENTAL TREATMENT OR TECHNOLOGY.—The requirements of this clause are met if such coverage decision is based on a determination that provision of a particular item or service that would otherwise be covered under the terms of the plan is excluded from coverage under the terms of the plan because the provision of such item or service—

"(I) does not meet the plan's requirements for medical appropriateness or necessity; or

"(II) would constitute an investigational item or experimental treatment or technology.

"(ii) CATEGORICAL EXCLUSION OF ITEM OR SERVICE REQUIRING EVALUATION OF MEDICAL FACTS OR EVIDENCE.—The requirements of this clause are met if—

"(I) such coverage decision is based on a determination that a particular item or service is not covered under the terms of the plan because provision of such item or service is categorically excluded from coverage under the terms of the plan, and

"(II) an independent contract expert finds under subparagraph (C), in advance of any review of the decision under subparagraph (D), that such determination primarily requires the evaluation of medical facts or medical evidence by a health professional.

"(iii) SPECIFIC EXCLUSION OF ITEM OR SERVICE REQUIRING EVALUATION OF MEDICAL FACTS OR EVIDENCE.—The requirements of this clause are met if—

"(I) such coverage decision is based on a determination that a particular item or service is not covered under the terms of the plan because provision of such item or service is specifically excluded from coverage under the terms of the plan, and

"(II) an independent contract expert finds under subparagraph (C), in advance of any review of the decision under subparagraph (D), that such determination primarily requires the evaluation of medical facts or medical evidence by a health professional.

"(iv) MATTERS SPECIFICALLY NOT SUBJECT TO REVIEW.—The requirements of subparagraphs (B), (C), (D), and (E) shall not apply in the case of any adverse coverage decision if such decision is based on—

"(I) a determination of eligibility for benefits,

"(II) the application of explicit plan limits on the number, cost, or duration of any benefit, or

"(III) a limitation on the amount of any benefit payment or a requirement to make copayments under the terms of the plan.

Review under this paragraph shall not be available for any coverage decision that has previously undergone review under this paragraph.

"(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of (i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or (ii) $25, with such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be

required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (D)(iii) is to reverse or modify the coverage decision.

"(C) REQUEST TO INDEPENDENT CONTRACT EXPERTS FOR DETERMINATION OF WHETHER COVERAGE DECISION REQUIRED EVALUATION OF MEDICAL FACTS OR EVIDENCE.—

"(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of clause (ii) or (iii) of subparagraph (A) are met (and review is not otherwise precluded under subparagraph (A)(iv)), the terms of the plan shall provide for a procedure for initial review by an independent contract expert selected by the plan under which the expert will determine whether the coverage deci-

sion requires the evaluation of medical facts or evidence by a health professional. If the expert determines that the coverage decision requires such evaluation, reconsideration of such adverse decision shall proceed under this paragraph. If the expert determines that the coverage decision does not require such evaluation, the adverse decision shall remain the final decision of the plan.

"(ii) INDEPENDENT CONTRACT EXPERTS.—For purposes of this subparagraph, the term 'independent contract expert' means a professional—

"(I) who has appropriate credentials and has attained recognized expertise in the applicable area of contract interpretation;

"(II) who was not involved in the initial decision or any earlier review thereof; and

"(III) who is selected in accordance with subparagraph (G)(i) and meets the requirements of subparagraph (G)(ii).

"(D) RECONSIDERATION OF INITIAL REVIEW DECISION.—

"(i) IN GENERAL.—In the case of a request for review made by a participant or beneficiary as described in subparagraph (A), if the requirements of subparagraph (A)(i) are met or reconsideration proceeds under this paragraph pursuant to subparagraph (C), the terms of the plan shall provide for a procedure for such reconsideration in accordance with clause (ii).

"(ii) PROCEDURE FOR RECONSIDERATION.—The procedure required under clause (i) shall include the following—

"(I) One or more independent medical experts will be selected in accordance with subparagraph (F) to reconsider any coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title.

"(II) The record for review (including a specification of the terms of the plan and other criteria serving as

the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record.

"(III) Such expert or experts will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title. Such reconsideration shall include the initial decision of the plan, the medical condition of the patient, and the recommendations of the treating physician. The experts shall take into account in the course of such reconsideration any guidelines adopted by the plan through a process involving medical practitioners and peer-reviewed medical literature identified as such under criteria established by the Food and Drug Administration.

"(IV) Such expert or experts will issue a written decision affirming, modifying, or reversing the initial re-

view decision, setting forth the grounds for the decision.

"(E) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph (including any review under subparagraph (C)) shall be completed before the end of the reconsideration period (as defined in paragraph (10)(L)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

"(F) INDEPENDENT MEDICAL EXPERTS.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

"(I) who is a physician or, if appropriate, another medical professional;

"(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field;

"(III) who was not involved in the initial decision or any earlier review thereof;

"(IV) who has not history of disciplinary action or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, health carrier, government, or regulatory body; and

"(V) who is selected in accordance with subparagraph (G)(i) and meets the requirements of subparagraph (G)(ii).

"(G) SELECTION OF EXPERTS.—

"(i) IN GENERAL.—An independent contract expert or independent medical ex-

pert is selected in accordance with this clause if—

"(I) the expert is selected by an intermediary which itself meets the requirements of clause (ii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert; or

"(II) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence, including selection by the plan in cases where it is determined that a suitable intermediary is not reasonably available,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (ii).

"(ii) INDEPENDENCE REQUIREMENTS.—An independent contract expert or independent medical expert or another entity described in clause (i) meets the independence requirements of this clause if—

"(I) the expert or entity is not affiliated with any related party;

"(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity;

"(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review; and

"(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

"(iii) RELATED PARTY.—For purposes of clause (i)(I), the term 'related party' means—

"(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer);

"(II) the physician or other medical care provider that provided the medical care involved in the coverage decision;

"(III) the institution at which the medical care involved in the coverage decision is provided;

"(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision; or

"(V) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision.

"(iv) AFFILIATED.—For purposes of clause (ii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

"(H) MISBEHAVIOR BY EXPERTS.—Any action by the expert or experts in applying for their selection under this paragraph or in the course of carrying out their duties under this paragraph which constitutes—

"(i) fraud or intentional misrepresentation by such expert or experts, or

"(ii) demonstrates failure to adhere to the standards for selection set forth in subparagraph (G)(ii),

shall be treated as a failure to meet the requirements of this paragraph and therefore as a cause of action which may be brought by a fiduciary under section 502(a)(3).

"(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

"(A) IN GENERAL.—In accordance with such regulations (if any) as may be prescribed by the Secretary for purposes of this paragraph, in the case of any initial coverage decision for benefits under paragraph (2)(A)(ii) or (2)(B)(ii), a group health plan may provide an alternative dispute resolution procedure meeting the requirements of subparagraph (B) for use in lieu of the procedures set forth under the preceding provisions of this subsection relating review of such decision. Such procedure may be provided in one form for all participants and beneficiaries or in a different form each group of similarly situated participants and beneficiaries.

"(B) REQUIREMENTS.—An alternative dispute resolution procedure meets the requirements of this subparagraph, in connection with any initial coverage decision, if—

"(i) such procedure is utilized solely—

"(I) accordance with the applicable terms of a bona fide collective bargaining agreement pursuant to which

the plan (or the applicable portion thereof governed by the agreement) is established or maintained, or

"(II) upon election by all parties to such decision,

"(ii) the procedure incorporates time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii);

"(iii) the procedure incorporates any otherwise applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures); and

"(iv) the means of resolution of dispute allow for adequate presentation by each party of scientific and medical evidence supporting the position of such party.

"(C) WAIVERS.—In any case in which utilization of the alternative dispute resolution procedure is voluntarily elected by all parties in connection with a coverage decision, the plan

may require or allow under such procedure (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) any party to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

"(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

"(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations; and

"(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

"(7) REVIEW REQUIREMENTS.—In any review of a decision issued under this subsection—

"(A) the record below shall be maintained for purposes of review in accordance with standards which shall be prescribed in regulations of the Secretary designed to facilitate such review, and

"(B) any decision upon review which modifies or reverses a decision below shall specifically set forth a determination that the record upon review is sufficient to rebut a presumption in favor of the decision below.

"(8) COMPLIANCE WITH FIDUCIARY STANDARDS.—The issuance of a decision under a plan upon review in good faith compliance with the requirements of this subsection shall not be treated as a violation of part 4.

"(9) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

"(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

"(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

"(10) OTHER DEFINITIONS.—For purposes of this subsection—

"(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by, or (if expressly authorized) on behalf of, a participant or beneficiary after such medical care has been provided.

"(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute

an advance determination of coverage (as defined in subparagraph (C)).

"(C) ADVANCE DETERMINATION OF COVERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

"(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by, or (if expressly authorized) on behalf of, a participant or beneficiary before such medical care is provided.

"(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the

proposed medical care constitutes accelerated need medical care.

"(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

"(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes accelerated need medical care.

"(H) ACCELERATED NEED MEDICAL CARE.—The term 'accelerated need medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that the participant or beneficiary is stabilized and—

"(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

"(I) placing the health of such participant or beneficiary (or, with respect to such a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

"(II) serious impairment to bodily functions; or

"(III) serious dysfunction of any bodily organ or part; or

"(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

"(I) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

"(J) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of

30 days, or such longer period as may be prescribed in regulations of the Secretary.

"(K) ACCELERATED NEED DECISION PERIOD.—The term 'accelerated need decision period' means a period of 5 days, or such longer period as may be prescribed in regulations of the Secretary.

"(L) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

"(i) in the case of a decision involving urgent medical care, such term means the urgent decision period; and

"(ii) in the case of a decision involving accelerated need medical care, such term means the accelerated need decision period.

"(M) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

"(N) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

"(O) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

"(P) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

"(Q) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

"(R) WRITTEN OR IN WRITING.—

"(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a generally recognized printable

or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

"(ii) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEMS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.".

SEC. 3. CLARIFICATION OF ERISA PREEMPTION RULES.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

"(d) The procedures and remedies required or provided under sections 502 and 503 in connection with—

"(1) review of claims for benefits under employee benefit plans and for review of decisions denying such claims (including review of coverage decisions referred to in section 503(b) and decisions upon review of such coverage decisions), and

"(2) causes of action brought to recover plan benefits, to enforce rights under the terms of the plan or this title, or to clarify rights to future benefits under the terms of the plan or this title,

are the exclusive procedures and remedies with respect to any such review or cause of action and supersede any provision of State law providing for any such review or cause of action.".

(b) CONFORMING AMENDMENT.—Section 514(b)(2)(A) of such Act (42 U.S.C. 1144(b)(2)(A)) is amended by inserting "or subsection (d)" after "subparagraph (B)".

SEC. 4. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this Act shall apply with respect to grievances arising in plan years beginning on or after January 1 of the second calendar year following 12 months after the date the Secretary of Labor issues all regulations necessary to carry out amendments made by this Act.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this Act, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before the date of issuance of final regulations issued in connection with such requirement, if the plan or issuer has sought to comply in good faith with such requirement.

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

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